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Testimony Presented to the House Ways and Means Committee:

"The Status of the Medicare Advantage Program"

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Mr. Chairman, Ranking Member Stark, and members of the subcommittee, thank you for the opportunity to participate in this very important hearing on "The Status of the Medicare Advantage Program."

I want to make a few points with my testimony today.

First, contrary to what is often stated, Medicare Advantage (MA) plans *are not* less efficient than the traditional Medicare fee-for-service (FFS) program. Data from the Medicare Payment Advisory Commission (MedPAC) confirms this fact. Comparing apples to apples, MA plans, and especially MA HMOs, can provide the Medicare benefit package to seniors at a cost well below that of FFS. In 2012, based on bids from the plans, MedPAC reports that the average MA plan provides Medicare benefits at 98 percent of FFS costs. And the MA HMO plans did so at just 95 percent of FFS costs.[1]

[1] *Healthcare Spending and the Medicare Program: A Data Book*, Medicare Payment Advisory Commission, June 2012, p. 146 (http://www.medpac.gov/chapters/Jun12DataBookSec9.pdf).

It's clear from this data that MA HMOs, which have, by far, the largest enrollment numbers — 11.4 million as of February 2012, according to MedPAC — have built the capacity over many years to deliver care more efficiently than FFS. This should not be surprising. Medicare FFS is an extremely inefficient model. It breeds fragmentation and undermines coordination, leading to low-quality care for many seniors. The emphasis from the Centers for Medicare and Medicaid Services (CMS) on quality in the MA program is admirable. It would be even more effective if FFS were rated on the same metrics.

There is ample evidence that the United States continues to experience much waste in the health care delivery system, and shockingly low quality too. Recent Institute of Medicine studies leave little doubt about that.[2] But what is often not stated is Medicare FFS's role in the problem. Medicare FFS is the dominant payer in many markets, and its rate setting regulations become the default option for other payers too. The sheer size of Medicare FFS ensures that the entire delivery system is organized around its incentives. For those looking for the reasons American health care continues to perform poorly in important ways, they need look no further than Medicare FFS and its influence on how care is delivered for everyone.

My second point is that the reductions in MA payments contained in the 2010 health care law will raise costs for seniors and force many of them out of their MA plans. The cuts are very deep. According to the Congressional Budget Office (CBO), the total

[2] See, for instance, *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Institute of Medicine, September 6, 2012 (http://iom.edu/Reports/2012/Best-Care-at-Lower-Cost-The-Path-to-Continuously-Learning-Health-Care-in-America.aspx).

ten-year cut in MA payments is now estimated at $308 billion: $156 billion in direct MA payment cuts and $152 billion in indirect MA reductions from the interactions with the other FFS cuts contained in the law.[3] That these cuts will directly impact the beneficiaries is indisputable. According to the most recent Trustees' Report, enrollment in MA will peak in 2013 at 13.7 million and then fall to 9.7 million in 2017.[4] Further, by law, MA plans must provide some percentage of the difference between their bids and the benchmark to the beneficiaries in the form of expanded benefits. Thus, reducing MA payments will, by definition, reduce benefits provided through MA plans to current enrollees. I co-authored a study with Robert Book in which we estimated that the average cut per MA enrollee would reach $3,700 by 2017.[5]

Why, if these cuts are so deep, has MA enrollment grown in 2012 and 2013? The answer is simple. For starters, the cuts are back-loaded. Through 2013, less than 10 percent of the scheduled Medicare reductions will have gone into effect, and costs have risen modestly in recent years because of the slow economy. More importantly, CMS has sent an unprecedented, and perhaps unlawful, $8.3 billion to MA plans, filling in over 70 percent of the cuts in 2012 alone — quite plainly because the agency wants to mitigate the impact of the cuts required by the 2010 law. There is no other way to explain what they are doing. Certainly there is no public policy rationale for the payments, as the

[3] Senate Finance Committee Minority Staff Press Release, September 19, 2012 (http://www.finance.senate.gov/newsroom/ranking/release/?id=9d69a54a-9a59-42b0-a1d4-5676c824440e).
[4] *2012 Annual Report of the Board of Trustees of the Federal Hospital Insurance and the Supplementary Medical Insurance Trust Funds*, April 2012, Table IV.C1, p. 180 (http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf).
[5] "Reductions in Medicare Advantage Payments: The Impact on Seniors by Region," Robert A. Book, Ph.D. and James C. Capretta, The Heritage Foundation, Backgrounder #2464, September 14, 2010 (http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf).

Government Accountability Office (GAO) has indicated.[6] Once the artificial and temporary bump-up in payments is terminated, as it inevitably will be, MA plans will be forced to pare back benefits, and enrollment in the plans will drop.

My third point is that MA plans are particularly important for lower-income seniors, and cuts in MA payments will hit this population hardest. Lower-income seniors are disproportionately represented in MA plans because they find the reduced cost-sharing in these plans attractive, especially at premiums that are usually well below the cost of Medigap coverage. In the 2010 study I co-authored with Robert Book, we used earlier findings from AHIP to estimate that beneficiaries with incomes between $10,800 and $21,600 were 19 percent more likely than the average beneficiary to enroll in an MA plan.[7]

The MA program has important features for the future of the Medicare program. MA plans can provide innovations in ways that Medicare FFS cannot because MA is not bound by FFS's payment structures. Moreover, the presence of the MA program ensures some level of choice for the beneficiaries, which is important for program accountability.

In recent years, there's been a lot of discussion of "delivery system reform." MA HMOs have proven that they can, in many parts of the country, deliver Medicare benefits

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[6] Testimony presented to the House Oversight Committee, James Cosgrove, Ph.D., U.S. Government Accountability Office, July 25, 2012 (http://oversight.house.gov/wp-content/uploads/2012/07/GAO-Cosgrove-Emmanuelli-Perez-Testimony-Medicare-Advantage-7-25-COMPLETE1.pdf).

[7] Book and Capretta, September 2012 (http://thf_media.s3.amazonaws.com/2010/pdf/bg2464.pdf). See also "Low-Income and Minority Beneficiaries in Medicare Advantage Plans, 2006," America's Health Insurance Plans (AHIP), Center for Policy and Research, September 2008 (http://www.ahipresearch.org/pdfs/MALowIncomeReport2008.pdf).

at less cost than FFS, and many plans have developed innovative tools to improve the quality of care for their patients. That is something that should be built upon, not discarded.